STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445207	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEXFORD HOUSE, THE	2421 JOHN B DENNIS HIGHWAY KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #32047, #32317, were completed on September 3-5, 2013, at The Wexford House. No deficiencies were cited related to the complaint investigation #32047 and #32314 under CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to provide an environment that maintains or enhances each resident's dignity of thirteen of thirteen observed resident's during the dining observation, and failed to respect the dignity with serving meals timely for one (#49) of ten residents observed for meals served in resident rooms. The findings included: Observation in the Main Dining Room on September 3, 2013, at 10:45 a.m., revealed three Certified Nursing Assistants (CNAs) placing large clothing protectors on the resident's chest without asking the resident prior to placement. Continued observation revealed five residents removed the clothing protectors immediately after the staff had placed them over their chest.	F 241	1. The staff (Nursing and C.N.A.) working in the dining room with the next meal, asked all residents if they did or did not want a clothing protector per the facility's Clothing Protector Policy. If they did not, then the protector was not placed on them during their meal. Resident #49 had her tray delivered at the same time as her room mate beginning with the next meal. 2. All other residents in the facility beginning with the next meal, were asked per the facility's Clothing Protectors Policy if they did or did not wish to have a clothing protector placed on them during their meal. All other residents in the facility beginning with the next meal, were also checked to make sure that they had their meal tray delivered at the same time as their room mate if they were both dining in their room. 3. A systematic approach to prevent residents from having a clothing protector placed on them during their meal will be to NOT have them applied unless the resident	10/01/13 Cont.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/19/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Review of facility policy, Clothing Protectors, last revised on July 2013 revealed "...ask resident if they prefer clothing protector during meals...if does not prefer...DO NOT place one on resident..." Interview with the General Dietary Manager on September 3, 2013, at 11:00 a.m., in the Main Dining Room confirmed the facility had failed to follow the facility's policy regarding clothing protectors. Resident #49 was re-admitted to the facility on March 7, 2013, with diagnoses including Anemia, Congestive Heart Disease, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease. Medical record review of the Quarterly Minimum Data Set dated August 15, 2013, revealed the resident score eight of fifteen on the Brief Interview for Mental Status assessment indicating moderate cognitive impairment, was at risk for malnutrition, and was able to feed self with supervision. Observation in the resident's room on September 3, 2013, at 11:33 a.m., revealed the resident's roommate was served the lunch tray. Continued observation revealed staff pulled the privacy curtain while the roommate was fed lunch by staff. Further observation revealed resident #49 had not been served lunch and when the staff took the roommates lunch tray from the room, resident #49 asked the staff member where his/her lunch was. Continued observation revealed the staff member replied the tray would	F 241	Cont. has been assessed for the need, a consent for placement has been signed by the resident or POA and it is care planned in the resident's medical record. Prior to meal services, the nursing/C.N.A. staff will still ask the resident's permission to place a clothing protector on them. This process will be audited on a daily bases by the QA Nurse or C.N.A. assigned to the dining room during the resident's meal time. The results of this audit will be turned in to the QA Manager or Dietary Operations Manager on a daily bases to be included in her weekly audits. All residents who received their meal in their room will also have their room mate receiving their tray at the same time. This process will be audited on a daily bases by the Unit C.N.A. SV or Unit S.V. for compliance. The results of the audits will be turned in each day along with the C.N.A. SV's other Daily Compliance Audits. 4. Monitoring by the QA Nursing Manager to ensure that Clothing Protector are not being used without consent and trays for both room mates are being delivered at the same time will be done on a weekly bases per review of these audit tools. The results of these audits will be presented in the monthly facility Quality Assurance meeting.	

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F 241	Continued From page 2 be delivered later. Interview in resident #49's room on September 3, 2013, at 12:20 p.m., revealed the resident was still waiting for the lunch tray and stated was "hungry." Observation on September 3, 2013, at 12:40 p.m., in resident #49's room, revealed the resident received the lunch tray. Interview with Licensed Practical Nurse #4 on September 3, 2013, at 12:25 p.m., revealed the resident's tray would probably come in about fifteen minutes, it was the routine for resident #49's roommate to receive the lunch tray first and much later resident #49 received theirs. Continued Interview confirmed resident #49's dignity was not respected by waiting over an hour for the lunch tray after the roommate had finished their meal.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	1. Resident #150 immediately had her care plan updated on 9/04/13 to reflect her dental needs. 2. All other residents in the facility were reviewed on 9/05/13 to ensure that their dental needs (if any) were also placed on their care plan. All Unit Managers were in-serviced on the need to place any of their resident's dental needs on their care plans in a timely manner. 3. A systematic approach to prevent residents from not having their dental needs addressed on their care plans will be to have the dental needs reviewed on a quarterly bases and if any, then	10/01/13 Cont.

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F 279	Continued From page 3 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan for the dental needs of one resident (#150) of thirty-five residents reviewed. The findings included: Resident #150 was admitted to the facility on January 23, 2013, with diagnoses including Anxiety, Psychotic Disorder, Depression, and Respiratory Failure. Observation and interview with the resident on September 4, 2013, at 8:43 a.m., in the resident's room revealed the resident had several missing teeth. Continued interview revealed the resident had two partials placed which had broke. Interview and medical record review of a dental progress note dated November 15, 2012, with Social Services Director #1 on September 4, 2013, at 9:12 a.m., at the 500 hall nurse's desk confirmed the resident did have two partials in the past that had been broken. Continued interview revealed the dental service was already scheduled to replace the residents partial free of charge. Interview with Minimum Data Set (MDS)	F 279	Cont. refer the resident to the visiting dental service per the quarterly visit. Once the resident has been scheduled for a dental visit, this need will be updated in the resident's care plan. In the event of an emergency related to the resident's dental needs, the POA and/or resident will be notified and arrangements made for care. The RD will assess the resident for potential declines & address care accordingly. A quarterly care plan audit will be conducted by the QA Nursing SV or Unit Manager for dental services to ensure that all dental needs are met for the resident. The results of this audit will be turned in to the QA Manager on a monthly bases to ensure compliance. 4. Monitoring by the QA Nursing Manager to ensure that dental needs are being met and documented per the resident's care plan will be done on a monthly bases per review of these audit tools. The results of these audits will be presented in the monthly facility Quality Assurance meeting.	

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F 279	Continued From page 4 Coordinator #1 and medical record review of the resident's Care Plan revised on August 9, 2013, on September 4, 2013, at 9:16 a.m., at the 500 hall nurse's desk revealed no documentation of the resident dental needs. Continued interview at this time with the MDS Coordinator #1 confirmed the facility had failed to develop a Care Plan to address the resident's dental needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to revise the care plan to address fall	F 280	1. Resident #65 immediately had her care plan updated on 9/05/13 to include the interventions of the pad alarm, ¾ side rails and PSA to prevent falls. These interventions were had been discussed prior to implementation with the resident's POA. 2. All other residents in the facility who had falls had their care plans reviewed on 9/06/13 to ensure that all interventions were noted on the plan. The resident and/or POA will be given notification and have the right to participate in the establishment of any interventions to prevent falls. All Unit Managers were in-serviced on the need to place all interventions for falls on the resident's care plan in a timely manner. 3. A systematic approach to having the resident and/or POA given the right to participate in the establishment of any interventions to prevent falls will be to have a discussion for approval with them prior to implementation of the intervention. This approval will be noted on an audit tool that is	10/01/13 Cont.

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F 280	Continued From page 5 interventions for one resident (#65) of thirty-five residents reviewed. The findings included: Resident #65 was re-admitted to the facility on March 19, 2013, with diagnoses including Vascular Dementia with Depressed Mood, Embolism and Thrombosis Arteries Lower Extremity, Cellulitis and Abscess of Leg except foot, Pneumonia, Hemiplegia due to Cerebral Vascular Accident, Atrial Fibrillation, Osteoarthritis, and Congestive Heart Failure. Review of a facility fall investigation dated August 27, 2013, revealed at 8:35 p.m., the resident was found on the bedroom floor sitting next to the bed with the bed pad alarm sounding, had ½ side rails in the up position, and had no injuries. Continued review revealed "...Interventions implemented to reduce the resident's risk for falls: PSA (Personal Safety Alarm) alarm applied..." Review of a facility fall investigation dated August 28, 2013, at 12:05 a.m., revealed the resident was again found sitting on the floor next to the bed, with no injuries, the bed pad alarm and the PSA were in place, and the side rails were in the up position. Medical record review of the August 2013 Physician's Recapitulation Orders revealed the resident used ½ side rails on both sides of the bed, and on August 28, 2013, the Physician ordered ¾ side rails on both sides of the bed. Medical record review of the Care Plan revised on August 21, 2013, revealed a problem for the resident's risk for falls, but did not reveal the use	F 280	Cont. conducted on a monthly bases. A systematic approach to prevent residents from not having their fall interventions addressed on their care plans will be to have the care plans reviewed on a monthly bases per an audit tool by the QA Nursing SV or Unit Manager. The results of this audit will be turned in to the QA Nursing Manager on a monthly bases to ensure compliance. 4. Monitoring by the QA Nursing Manager to ensure that all the resident's fall care plans are being updated after their approval of intervention interventions as needed will be audited on a monthly bases per an audit tool. The results of these audits will be presented in the monthly facility Quality Assurance meeting.	

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F 280	Continued From page 6 of the PSA, pressure pad alarm for the bed, and the 3/4 side rails on both sides of the bed. Observation on September 5, 2013, at 8:00 a.m., in the resident's room revealed the resident in the bed with 3/4 side rails in the up position on both sides of the bed, a PSA alarm in place, and a pressure pad alarm in place. Review of the facility policy, Fall Protocols, revised April 2000 revealed "...Update care plan with fall prevention interventions..." Interview with the Licensed Practical Nurse Assistant MDS Coordinator on September 5, 2013, at 9:10 a.m., in the conference room confirmed the use of the bed pressure alarm, PSA, and ¾ side rails, were not addressed on the Care Plan.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete an assessment and	F 315	1. Resident #223 had her occasional incontinence addressed per the implementation of a Bowel and Bladder Program on 9/18/13 (after the facility's Bowel & Program was revised). 2. All other residents in the facility that qualified for implementation of the Bowel & Bladder Program were assessed and added (if needed) to the case load effective on 9/23/13. All Unit Managers, MDS Staff and the Restorative Nursing Staff were in-serviced on the criteria (along with its process) for placing a resident on the facility's Bowel & Bladder Program in a timely manner.	10/01/13 Cont.

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F 315	Continued From page 7 develop an individualized toilet plan for one resident (#223) of thirty-five residents reviewed. The findings included: Resident #223 was admitted to the facility on May 14, 2013, with diagnoses including Lack of Coordination, Muscle Weakness, Osteoarthrosis, Depressive Disorder, Anxiety Disorder, and Psychosis. Medical record review of the admission Minimum Data Set (MDS) dated May 20, 2013, revealed resident occasionally incontinent of bladder and frequently incontinent of bowel. Continued medical record review of a change in status MDS dated June 21, 2013, revealed resident always incontinent of bladder and bowel. Interview with the Restorative Nurse on September 4, 2013, at 3:53 p.m., in the restorative office, confirmed the facility had failed to complete a thorough bowel and bladder assessment on admission and had failed to reassess after a decline in bowel and bladder for resident #223.	F 315	Cont. 3. A systematic approach to evaluating the resident for the facility's Bowel & Bladder Program will be to follow the facility's revised Bowel & Bladder Program for qualifying criteria. The Bowel & Bladder Program will be monitored weekly by the Restorative Nurse and audited on a monthly bases to ensure that all residents who qualified for the program are appropriately added to the case load. The audit will be preformed by the QA Nursing SV, Unit Managers or Restorative Manager. The results of this audit will be turned in to the QA Nursing Manager on a monthly bases to ensure compliance. 4. Monitoring by the QA Nursing Manager to ensure that all the residents who qualify for the facility's Bowel & Bladder Program are being appropriately Cont. (See Attachment)	
F 356 SS=F	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356	1. The Nursing Staffing Information was posted immediately in the front lobby on the receptionist desk once it was called to the attention of administration as not been in place on 9/03/13. Note: The Nursing Staffing Report was already posted on each of the Nursing Units at the Nurses Desk but had not been posted at the Front Desk yet.	10/01/13 Cont.

F 315 Bowel & Bladder Assessment

Cont.
added to the case load will be audited on a monthly bases per an audit tool. The results of these audits will be presented in the monthly facility Quality Assurance meeting.

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F 356	Continued From page 8 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post accurate nurse staffing information as required. The findings included: Observation on September 3, 2013, at 11:00 a.m., at the front lobby revealed the staffing information was not posted. Interview with the Director of Nursing on September 3, 2013, at 11:10 am, confirmed no staffing information was posted and the facility had failed to post accurate staffing.	F 356	Cont. 2. All days following the date of 9/03/13, the Nursing Staffing Report was posted in the front lobby on the Receptionist Desk (as well as on all Nursing Units at the Nurses Desk) by 8:00 am. All Unit Managers, the Staffing Coordinator, QA C.N.A. SV's and all Receptionists were in-serviced on the need to make sure the Nursing Staffing Report is in place by 8:00 am each day for the publics viewing. 3. A systematic approach to ensure the Nursing Staffing Report is appropriately posted each day by 8;00 am each will be to have the Receptionist for Day Shift post it each am when she arrives for her shift at 8:00 am. The Unit Nursing Managers, QA C.N.A. SV or House SV will ensure that it is posted on each Nursing Unit by 8:00 am. The posting of the Daily Nurse Staffing information will be audited on a daily bases for compliance by the QA C.N.A. SV or House SV per an audit tool. The results of this audit will be turned in to the QA Manager on a weekly bases to ensure compliance. 4. Monitoring of the posted Nurse Staffing information by the QA Nursing Manager to ensure that compliance is being met will be done on a monthly bases per review of these audit tools. The results of these audits will be presented in the monthly facility Quality Assurance meeting.	

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F 371 F 371 SS=F	Continued From page 9 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary storage of food and equipment used for preparation of food for residents. The findings included: Observation of the dietary department on September 3, 2013, from 10:40 a.m. until 11:00 a.m., revealed the following available for resident use: 1. Food processor was stored wet. 2. Dry food particles in stand up mixing bowl and around rim. 3. One gallon of Vinegar was opened and undated on the prep table shelf. 4. 16 ounce of Chicken Stock in the reach in cooler was opened and undated.	F 371 F 371	1. The facility immediately provided sanitary storage of food and equipment used for preparation of food for residents by the following: a) the food processor that was stored wet was immediately returned to the dish room for proper wash and dry procedures b) the dry food particles in stand up mixing bowl and around the rim was taken immediately to the dish room for proper wash and dry procedures c) the one gallon of vinegar that was found to be open and undated on the prep table shelf was immediately discarded d) 16 ounce of Chicken stock in the reach in cooler was opened and undated was immediately discarded e) the 64 ounce container of BBQ Sauce in reach in cooler that was opened and undated immediately discarded f) the opened container of cream corn with an expiration date of September 2, 2013 in the reach in cooler immediately discarded g) the one container of Cole Slaw with the expiration date of August 29, 2013 in the reach in cooler was immediately discarded h) the one container of spinach with expiration date of September 2, 2013 in the reach in cooler was immediately discarded i) the dirty can opener on the side of the prep table was immediately taken to the dish room for proper wash and dry procedure j) the two dented 106 ounce cans of sliced peaches on the	10/01/13 Cont.

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F 371	Continued From page 10 5. 64 ounces container of BBQ Sauce in reach in cooler was opened and undated. 6. Open container of Cream Corn with expiration date of September 2, 2013 in the reach in cooler. 7. Open container of Cole Slaw with expiration date of August 29, 2013 in the reach in cooler. 8. Open container of spinach with expiration date of September 2, 2013 in the reach in cooler. 9. Dirty can opener on side of prep table. 10.Two dented 106 ounce cans of Sliced Peaches on dry storage shelf. 11.One drawer under prep table of scoops and large serving spoons with a greasy covering to all utensils. Interview with the Dietary Manager in the dietary department on September 3, 2013, at 11:00 a.m., confirmed the food processor was stored wet, the standup mixer was stored dirty, the Vinegar, Chicken Stock, and BBQ sauce did not have an opened date on it, expired containers of Cream Corn, Cole Slaw, and Spinach were in the reach in cooler, the can opener was stored dirty, there were two dented cans in the dry storage area, and all the scoops and large serving spoons were stored dirty in a drawer.	F 371	Cont. dry storage shelf were immediately removed to the shelf designated for dented cans k) the one drawer under the prep table of scoops and large serving spoons had a greasy covering to all utensils immediately had all items removed to the dish room for proper wash and dry procedure 2. All other equipment used preparation or opening of food for the residents were immediately checked for proper cleaning and sanitation. If any were found then they were removed to the dish room for proper wash and dry procedure. All other food items that were opened were checked for proper labeling, if any were found to be out of compliance, they were immediately discarded (Note: None were found). All other food items that were stored in the reach in were checked for proper expiration dates and if any were found to be out of compliance then all were immediately discarded (Note: None were found). All other cooking utensils were checked for greasy films and proper cleaning, if any were found then they were immediately Cont. (See Attachment)	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	I. The practice of washing the hands with Hand Sanitizer by the C.N.A. and Nursing Staff before handling a resident's meal tray began immediately with the next dining room meal on 9/04/13.	10/01/13 Cont.

F 371 Food Procure/Store/Prepare/Serve

Cont.

removed to the dish room for proper wash and dry procedures. All other cans in the dry storage areas were checked for any denting, if any were found they were removed to the shelf designated for dented cans (Note: None were found). All areas in question were immediately corrected and a teachable moment regarding the issues was done will 100% of all dietary staff.

3. A systematic approach to prevent opened foods in the refrigerator reach ins or supply areas from not being dated properly and food not being disposed of properly post the expiration date will be to have the Dietary Cook monitored the refrigerators/supply areas for compliance on a daily bases per an audit tool. The results of this audit will be turned in to the Dietary Operations Manager on a daily bases to be included in her weekly audit of the department.. All work areas, equipment used for food preparation for the residents including equipment storage areas, drawers, prep tables, etc. and cans of food will be audited for compliance on a weekly by the Dietary Operation Manager per an audit tool for cleanliness and sanitation.
4. Monitoring by the Dietary Operations Manager to ensure that the Dietary kitchen remains in compliance with regulations free of issues noted above will be done on a weekly bases per an audit tool. The results of this audit will be presented in the monthly facility Quality Assurance meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445207	A. BUILDING _____ B. WING _____	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEXFORD HOUSE, THE	2421 JOHN B DENNIS HIGHWAY KINGSPORT, TN 37660

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F 441	Continued From page 11 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to wash and/or	F 441	Cont. 2. All days following this date, the C.N.A.'s and Nursing staff continued to use hand sanitizer between handling each resident's tray to prevent infection control transmission between the staff and/or residents. All C.N.A.'s and Nursing Staff working in the dining room will be in-serviced on the practice of Hand Sanitization between handling each resident's tray. 3. A systematic approach to ensure infection control practices are in place to prevent cross contamination while the staff are passing our resident meal trays will be to have the Nurse in the Dining Room during the meal or C.N.A. SV be responsible to ensure there is hand sanitizer present for the C.N.A.'s during the meal and it is being used appropriately. The hand sanitization will be audited with each meal in the dining room to ensure compliance per an audit tool by the C.N.A. SV or Nurse assigned to the Dining Room during the meal. The results of this audit will be turned in to the QA Manager on a weekly bases to ensure compliance. 4. Monitoring of the hand sanitization by the staff in between passing out trays to each of the residents in the dining room during meal time will be monitored by the QA Nursing Manager to ensure that compliance is being met done on a weekly	Cont.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 12 sanitize their hands while serving food trays to the residents. The findings included: Observation in the resident's dining room on September 3, 2013, at 11:10 a.m., revealed Certified Nursing Assistant (CNA) #1, CNA #2, and CNA #3, handing out lunch trays and touching the resident's trays and residents without wearing gloves or washing hands. Continued observation revealed this occurred for thirteen of thirteen residents observed. Review of facility policy, Infection Control - Handwashing, last revised July 2009 revealed "...hand washing...soiled with body substances...before food preparation...when each resident's care is completed..." Interview with the General Dietary Manager in the hallway outside the main dining room on September 3, 2013, at 11:15 a.m., confirmed hands must be washed and/or santized prior to touching a resident's food or food tray and when contact has occurred with the resident. Continued interview with the General Dietary Manager confirmed the facility policy for handwashing had not been followed.	F 441	Cont. bases per review of the audit tool. The results of the audits will be presented in the monthly facility Quality Assurance meeting.	